



Veterans Health Care March 2003

1: Acad Med. 2003 Mar;78(3):270-4.

A Web-based compendium of clinical questions and medical evidence to educate internal medicine residents.

Crowley SD, Owens TA, Schardt CM, Wardell SI, Peterson J, Garrison S, Keitz SA. The authors designed an electronic database of clinical questions (CQs) and medical evidence and implemented it in 2001-02 at Duke University Medical Center and the Veterans Administration Medical Center in Durham, North Carolina. This Web-based data collection system is called the Critical Appraisal Resource (CAR) and is still in operation. This report is of ten months of the system's operation. During their medicine ward rotations, residents entered CQs into the CAR; they also entered Medline reference links and validated article summaries. Residents' utilization of the CAR database, Medline, and other electronic resources was prospectively measured. In addition, residents were prospectively surveyed regarding the impact of each question and associated reference on medical decision making for individual patients. Over ten months, residents entered 625 patient-based CQs into the CAR and were able to obtain useful information from the medical literature on 82% of the CQs they searched. The two most prevalent CQ types were therapy and diagnosis questions (53% and 22%). Sixty percent of the therapy articles considered useful were reports of randomized controlled trials. Residents obtained 77% of their useful data from Medline. They reported that obtaining useful data altered patient management 47% of the time. Residents used the CAR as a resource, searching the database for information 1,035 times over the study period. In summary, the use of an evidence-based critical appraisal resource led residents to engage the medical literature on behalf of their patients and influenced approximately half of their patient-care decisions. Residents benefited from questions previously searched by other residents, allowing them to address a wider spectrum of CQs during ward rotations. PMID: 12634206

2: Am Heart J. 2003 Mar;145(3):493-9.

History of depression, angina, and quality of life after acute coronary syndromes. Rumsfeld JS, Magid DJ, Plomondon ME, Sales AE, Grunwald GK, Every NR, Spertus JA.

BACKGROUND: Depression has been associated with higher mortality and morbidity rates after acute coronary syndromes (ACS), but little is known about the association between depression, angina burden, and quality of life. We evaluated the association between a history of depression and patient-reported angina frequency, physical limitation, and quality of life 7 months after discharge from the hospital for ACS.

METHODS: Patients were enrolled in the Department of Veterans Affairs Access to Cardiology Study, a cohort study of all patients with acute myocardial infarction or

unstable angina who were discharged from 24 Veterans Affairs medical centers between March 1998 and February 1999. Data from 1957 patients who completed a 7-month postdischarge Seattle Angina Questionnaire were analyzed. Multivariate logistic regression was used to evaluate a history of depression as an independent predictor of angina frequency, physical limitation, and quality of life 7 months after ACS, as measured with the Seattle Angina Questionnaire. RESULTS: A total of 526 patients (26.7%) had a history of depression. After adjustment for a wide array of demographic, cardiac, and comorbid factors, a history of depression was significantly associated with more frequent angina (odds ratio [OR] 2.40, 95% CI 1.86-3.10, $P < .001$), greater physical limitation (OR 2.89, 95% CI 2.17-3.86, $P < .001$), and worse quality of life (OR 2.84, 95% CI 2.16-3.72, $P < .001$) after ACS. CONCLUSION: We found a strong association between a history of depression and both heavier angina burden and worse health status after ACS. These findings further support the importance of depression as a risk marker for adverse outcomes after ACS. PMID: 12660673

3: Am Heart J. 2003 Mar;145(3):475-83.

Ergometric score systems after myocardial infarction: prognostic performance of the Duke Treadmill Score, Veterans Administration Medical Center Score, and of a novel score system, GISSI-2 Index, in a cohort of survivors of acute myocardial infarction. Villella M, Villella A, Santoro L, Santoro E, Franzosi MG, Maggioni AP; Duke Treadmill Score; Veterans Administration Medical Center Score; GISSI-2 Investigators.

BACKGROUND: The aims of the study were to evaluate the performance of the Duke Treadmill Score (DTS) and the Veteran Affairs Medical Center Score (VAMCS) in predicting 6-month death in GISSI-2 study survivors of acute myocardial infarction treated with thrombolytic agents, and to develop a simple predictive scoring system from the same database. METHODS: Patients of the GISSI-2 study ($n = 6251$) performed a maximal symptom-limited exercise test 1 month after myocardial infarction. We calculated for each patient the DTS and the VAMCS. Based on the coefficients of a multivariate analysis of our database, we developed a simple predictive scoring system and performed an internal validation. The prognostic value of each scoring system was assessed by multivariate analysis. RESULTS: Six-month mortality rates in the subgroups of each scoring system were as follows: DTS: low risk 0.6%, moderate risk 1.8%, high risk 3.4% ($P < \text{or} = .0001$); VAMCS: low risk 0.6%, moderate risk 1.9%, high risk 4.7% ($P < \text{or} = .0001$); GISSI-2 Index: low risk 0.5%, moderate risk 1.9%, high risk 6.1% ($P < \text{or} = .0001$). The results of multivariate analysis (relative risk [RR] and 95% CI) were as follows: DTS: moderate risk 2.50 (1.47-12.59), high risk 5.13 (3.61-15.55); VAMCS: moderate risk 2.65 (1.53-4.59), high risk 5.97 (3.10-11.49); GISSI-2 Index: moderate risk 3.16 (1.81-5.52), high risk 8.65 (4.36-17.18). CONCLUSIONS: The use of ergometric-derived prognostic score systems in a population of survivors of acute myocardial infarction treated with thrombolytic drugs distinguishes subgroups at different risks of death and allows an appropriate recourse to more costly procedures. PMID: 12660671

4: Am J Nurs. 2003 Mar;103(3):130-1.

Cadet Corps seeks Congressional recognition.

[No authors listed]

PMID: 12626953

5: Chest. 2003 Mar;123(3):725-30.

Spirometry testing standards in spinal cord injury.

Kelley A, Garshick E, Gross ER, Lieberman SL, Tun CG, Brown R.

STUDY OBJECTIVES: Because muscle paralysis makes it uncertain whether subjects with spinal cord injury (SCI) can perform spirometry in accordance with American Thoracic Society (ATS) standards, determinants of test failure were examined.

DESIGN: Cross-sectional study. SETTING: Veterans Affairs (VA) medical center.

PARTICIPANTS: Veterans with SCI at VA Boston Healthcare System and nonveterans recruited by mail and advertisement. Measurements and results: Two hundred thirty of 278 subjects (83%) were able to produce three expiratory efforts lasting ≥ 6 s and without excessive back-extrapolated volume (EBEV). In 217 of 230 subjects (94%), FVC and FEV(1) were each reproducible in accordance with 1994 ATS standards. In the remaining 48 subjects, efforts with smooth and continuous volume-time tracings and acceptable flow-volume loops were identified. These subjects had a lower percentage of predicted FVC, FEV(1), and maximum expiratory and inspiratory pressures compared to the others, and a greater proportion had neurologically complete cervical injury (42% compared to 16%). In 19 subjects (40%), some expiratory efforts were not sustained maximally for ≥ 6 s but had at least a 0.5-s plateau at residual volume (short efforts). In eight subjects (17%), some efforts were not short but had EBEV. In the remaining 21 subjects (44%), some efforts were short, some had EBEV, and some had both. If these efforts were not rejected, 262 of 278 subjects (94%) would have produced three acceptable efforts, and in 257 subjects (92%), the efforts were reproducible. CONCLUSIONS: Subjects with SCI with the most impaired respiratory muscles and abnormal pulmonary function are able to perform spirometry reproducibly despite not meeting usual ATS acceptability standards. Exclusion of these subjects would lead to bias in studies of respiratory function in SCI. The modification of spirometry testing standards to include efforts with EBEV and with a 0.5-s plateau if < 6 s would reduce the potential for bias.

PMID: 12628869

6: Drug Alcohol Depend. 2003 Mar 1;69(2):197-203.

Brief motivational feedback improves post-incarceration treatment contact among veterans with substance use disorders.

Davis TM, Baer JS, Saxon AJ, Kivlahan DR.

OBJECTIVES: To test the efficacy of providing brief motivational feedback to increase post-incarceration substance use disorders (SUD) treatment contact. DESIGN: Randomized clinical trial (feedback vs. control) with a 2-month post-incarceration follow-up. PARTICIPANTS: Veterans (N = 73) incarcerated in a county jail system who met SUD diagnostic criteria. MEASURES: Baseline assessment included the Addiction Severity Index, the Form-90 assessment of recent alcohol use, and a DSM-IV SUD criteria checklist. The primary outcome was Veterans Administration (VA) appointments. Secondary outcomes were the Addiction Severity Index-Followup and the Treatment Services Review. INTERVENTION: All participants received baseline assessment. The feedback condition received personalized feedback and encouragement to explore ambivalence about change and treatment in a single interview. RESULTS: Participants receiving feedback were more likely to schedule appointments at a VA addictions clinic within 60 days of their jail release dates (67 vs. 41%; $P < 0.03$). Though differences were not statistically significant, more feedback participants attended addictions clinic appointments (47 vs. 32%; ns) and were retained in addictions treatment at 90 days (31 vs. 14%; $P < 0.08$). Treatment appointments were more likely when intervention occurred close to release. Loss of participants to post-release follow-up interviews was $>50\%$, limiting power to detect significant differences by self-report. CONCLUSION: Brief motivational feedback shows promise as a way to link incarcerated individuals to SUD treatment services.

PMID: 12609701

7: Environ Health Perspect. 2003 Mar;111(3):335-41.

A delta-aminolevulinic acid dehydratase (ALAD) polymorphism may modify the relationship of low-level lead exposure to uricemia and renal function: the normative aging study.

Wu MT, Kelsey K, Schwartz J, Sparrow D, Weiss S, Hu H.

In this study we investigated whether a known delta-aminolevulinic acid dehydratase (ALAD) exon 4 polymorphism has a modifying effect on the association of blood or bone lead level with uricemia and indices of renal function among middle-aged and elderly men. We performed a cross-sectional study of subjects who participated between 1991 and 1995 in the Department of Veterans Affairs Normative Aging Study. Information on blood lead levels, bone lead levels (measured by K-shell X-ray fluorescence), serum uric acid, serum creatinine, estimated creatinine clearance, and ALAD polymorphism status was available in 709 subjects. Regression models were constructed to examine the relationships of serum uric acid, serum creatinine, and estimated creatinine clearance to blood or bone lead level, stratified by genotype. We also adjusted for age, body mass index, blood pressure, smoking, alcohol consumption, and ingestion of analgesic medications (n = 638). Of the 709 subjects, 7 (1%) and 107 (15%) were homozygous and heterozygous for the variant (ALAD-2) allele, respectively. The mean (range) serum uric acid and creatinine levels were 6.5 (2.9-10.6) and 1.2 (0.6-2.5) mg/dL. No significant differences were found in serum uric acid, serum creatinine, or estimated creatinine clearance by ALAD genotype. However, after adjusting for other potential confounders, we found a significant linear relationship between serum uric acid and patella bone lead (p = 0.040) among the ALAD 1-2/2-2 genotype individuals above a threshold patellar lead level of 15 micro g/g. In contrast, among the wild-type (ALAD 1-1) individuals, there was a suggestion of a significant linear relationship of serum uric acid with patella bone lead (p = 0.141), but only after a threshold of 101 micro g/g. There was evidence of a significant (p = 0.025) interaction of tibia lead with genotype (ALAD 1-1 vs. ALAD 1-2/2-2) regarding serum creatinine as an outcome, but in the same linear regression model tibia lead alone was not a significant predictor of serum creatinine. Conversely, for estimated creatinine clearance, patella lead, but not the interaction of patella lead with genotype, was a significantly independent predictor (p = 0.026). Our findings suggest that ALAD genotype may modify the effect of lead on the renal excretion of uric acid as well as overall renal function among middle-aged and elderly men who had community (nonoccupational) exposures to lead. Additional research is needed to ascertain whether this constitutes a true gene-environment interaction and, if so, its clinical impact.

PMID: 12611663

8: Gastrointest Endosc. 2003 Mar;57(3):295-9.

Impact of upper endoscopy on satisfaction in patients with previously uninvestigated dyspepsia.

Rabeneck L, Wristers K, Soucek J, Ambriz E.

BACKGROUND: In patients with uninvestigated dyspepsia who undergo endoscopy, the presence of abnormal findings guides subsequent management. However, upper endoscopy is "negative" in the majority of these patients, and the value of endoscopy in these individuals has been questioned. This study evaluated the impact of endoscopy on patient satisfaction in patients with previously uninvestigated dyspepsia. **METHODS:** The study was a secondary analysis of data obtained from a double-blind, randomized placebo-controlled trial, evaluating a 6-week course of omeprazole versus placebo in 140 patients with uninvestigated dyspepsia who were

followed for up to 1 year. The setting was the primary care outpatient clinics at the Houston Veterans Affairs Hospital. Participants had to be 18 years of age or older with at least a 1-week history of dyspepsia (epigastric discomfort) without alarm features. Satisfaction was measured at each visit with the Severity of Dyspepsia Assessment, a validated, reliable dyspepsia-related health measure that has a satisfaction scale (scores 2-23; higher scores indicate greater satisfaction). Patients unresponsive to empiric therapy with placebo or omeprazole based on predefined criteria underwent endoscopy. Severity of Dyspepsia Assessment satisfaction scores were analyzed for 5 visits: 2 closest in time to, but before, the day of endoscopy (Times 1 and 2); immediately before endoscopy (Time 3); and the 2 visits closest in time after endoscopy (Times 4 and 5). After determining there was no difference in treatment failure rates between patients who received placebo or omeprazole, data from these groups were combined. The mean Severity of Dyspepsia Assessment satisfaction scores for Times 1 through 5 in all patients who underwent endoscopy were compared as well as for subgroups with positive and negative endoscopic findings with a repeated-measures analysis of variance. RESULTS: Data on all 5 visits were available in 62 patients, 36 of whom had a negative endoscopy. For all patients the mean scores for Time 2 (8.5; 95% CI [7.4, 9.6]), and Time 3 (7.6; 95% CI [6.6, 8.6]) were significantly lower than those for Time 4 (13.7; 95% CI [12.2, 15.3]) and Time 5 (14.4; 95% CI [12.9, 15.9]). The mean score for Time 1 (11.1; 95% CI [9.5, 12.6]) was significantly lower than the mean score for Time 5. Similar significant improvements in satisfaction scores were observed in subgroups with negative and positive findings. CONCLUSIONS: In patients with previously uninvestigated dyspepsia, endoscopy leads to improved patient satisfaction regardless of the endoscopic findings. PMID: 12612505

9: J Am Coll Cardiol. 2003 Mar 19;41(6):893-904.
Choice of prosthetic heart valve for adult patients.
Rahimtoola SH.

This review summarizes the major long-term (> or =10 to 15 years) patient outcomes after insertion of many Food and Drug Administration approved prosthetic heart valves (PHV). Mechanical PHV was associated with a better survival ($p < 0.02$) at 15 years after aortic valve replacement (AVR) than with a bioprosthesis in the Department of Veterans Affairs (DVA) trial. In both the DVA and the Edinburgh Heart Valve trials, bioprosthesis were associated with structural valve deterioration (SVD) (mitral valve replacement [MVR] > AVR) and, therefore, for replacement of the PHV. Thromboembolism and bleeding rate were higher with mechanical PHV. Mortality after AVR and MVR is high at 10 to 15 years because of the associated comorbid conditions and older age of patients. Outcomes with "new" good valves are similar to that with "older" good valves. Complication rates of thromboembolism, bleeding, endocarditis, and leak vary widely; the rates of these complications are not different among different mechanical PHV and among different bioprosthetic PHV. Structural valve deterioration is rare with mechanical PHV. Structural valve deterioration of bioprosthesis after MVR is higher than after AVR; after AVR, homografts and bioprosthesis have similar rates of SVD. The exact rate of SVD of the pulmonary autograft is uncertain. Valve prosthesis-patient mismatch is clinically important when it is severe and in selected patients when it is moderate. Bioprosthesis have a low rate of SVD in the older patient and, thus, are the PHV of choice for AVR in patients > or =60 to 65 years of age and for MVR in patients > or =65 to 70 years of age; in younger patients mechanical valves are the PHV of choice. In individual patients there may be exceptions to these general rules. PMID: 12651032

10: J Am Geriatr Soc. 2003 Mar;51(3):380-6.

Predictors of alcohol-treatment seeking in a sample of older veterans in the GET SMART program.

Satre DD, Knight BG, Dickson-Fuhrmann E, Jarvik LF.

OBJECTIVES: To examine the predictive value of demographic characteristics and substance abuse indicators to explain treatment seeking for substance abuse problems by older male medical patients. DESIGN: Longitudinal analysis of screening data and treatment-seeking behavior. SETTING: Inpatient medical and outpatient substance abuse treatment center. PARTICIPANTS: Participants in the study were 855 medically ill male veterans aged 55 and older, who were screened for alcohol problems during inpatient medical treatment after clinician referral.

MEASUREMENTS: The CAGE alcohol screen (Cut down on your drinking, Annoyed by criticism of your drinking, Guilty about your drinking, Eye-opener), drug use, and demographic measures administered at time of screening. Predictors of treatment seeking in the sample were examined using structural equation modeling. RESULTS: Expressed interest in treatment and later attendance at a pretreatment evaluation were associated with younger age and a higher CAGE alcohol screening score. Being unmarried and using drugs in addition to alcohol were associated with treatment interest but not with evaluation attendance. In the path model tested, the effect of higher CAGE score partially explained the effect of younger age on treatment seeking. CONCLUSION: The model examined shows utility in predicting alcohol-treatment seeking in this sample. Age-related factors may deter treatment seeking by older male medical inpatients.

PMID: 12588582 [PubMed - indexed for MEDLINE]

11: J Am Geriatr Soc. 2003 Mar;51(3):314-22.

Physical performance measures in the clinical setting.

Studenski S, Perera S, Wallace D, Chandler JM, Duncan PW, Rooney E, Fox M, Guralnik JM.

OBJECTIVES: To assess the ability of gait speed alone and a three-item lower extremity performance battery to predict 12-month rates of hospitalization, decline in health, and decline in function in primary care settings serving older adults.

DESIGN: Prospective cohort study. SETTING: Primary care programs of a Medicare health maintenance organization (HMO) and Veterans Affairs (VA) system.

PARTICIPANTS: Four hundred eighty-seven persons aged 65 and older.

MEASUREMENTS: Lower extremity performance Established Population for Epidemiologic Studies of the Elderly (EPESE) battery including gait speed, chair stands, and tandem balance tests; demographics; health care use; health status; functional status; probability of repeated admission scale (Pra); and primary physician's hospitalization risk estimate. RESULTS: Veterans had poorer health and higher use than HMO members. Gait speed alone and the EPESE battery predicted hospitalization; 41% (21/51) of slow walkers (gait speed <0.6 m/s) were hospitalized at least once, compared with 26% (70/266) of intermediate walkers (0.6-1.0 m/s) and 11% (15/136) of fast walkers (>1.0 m/s) (P <.0001). The relationship was stronger in the HMO than in the VA. Both performance measures remained independent predictors after accounting for Pra. The EPESE battery was superior to gait speed when both Pra and primary physician's risk estimate were included. Both performance measures predicted decline in function and health status in both health systems. Performance measures, alone or in combination with self-report measures, were more able to predict outcomes than self-report alone.

CONCLUSION: Gait speed and a physical performance battery are brief, quantitative estimates of future risk for hospitalization and decline in health and function in

clinical populations of older adults. Physical performance measures might serve as easily accessible "vital signs" to screen older adults in clinical settings.
PMID: 12588574

12: J Clin Psychol. 2003 Mar;59(3):385-97.

Clinical presentations in combat veterans diagnosed with posttraumatic stress disorder.

Elhai JD, Frueh BC, Davis JL, Jacobs GA, Hamner MB.

This article investigated subtypes of symptom patterns among male combat veterans diagnosed with posttraumatic stress disorder (PTSD) through a cluster analysis of their Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher, Graham, Ben-Porath, Tellegen, Dahlstrom, & Kaemmer, 2001) clinical and validity scales.

Participants were 126 veterans seeking outpatient treatment for combat-related PTSD at a Veterans Affairs Medical Center. Two well-fitting MMPI-2 cluster solutions (a four-cluster solution and a three-cluster solution) were evaluated with several statistical methods. A four-cluster solution was determined to best fit the data.

Follow-up analyses demonstrated between-cluster differences on MMPI-2 "fake bad" scales and content scales, the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986), Mississippi Combat PTSD scale (M-PTSD; Keane, Caddall, & Taylor, 1988), and Clinician-Administered PTSD Scale (CAPS-1; Blake et al., 1990). Clusters also were different in disability-seeking status, employment status, and income.

Implications for research and clinical practice using the MMPI-2 with combat veterans presenting with PTSD are briefly addressed.

PMID: 12579553

13: J ECT. 2003 Mar;19(1):10-6.

Continuation and maintenance ECT in treatment-resistant bipolar disorder.

Vaidya NA, Mahableshwarkar AR, Shahid R.

Continuation and maintenance electroconvulsive therapy (c/mECT) is a treatment alternative for the long-term management of mood and psychotic disorders, especially in chronic, recurring, medication-resistant illnesses and in patients who are medication-intolerant, are non-compliant, and have a high risk of suicide with medications. A MEDLINE search was performed with maintenance electroconvulsive therapy (ECT), continuation ECT, and prophylactic ECT as keywords. The relevant literature was obtained and reviewed. Despite methodologic flaws, the overwhelming majority of the studies report the effectiveness of c/mECT in bipolar mood disorder.

We also reviewed the charts of 13 patients with mood disorder receiving maintenance ECT in the ECT service of a Veterans Administration medical center.

Despite good results, c/mECT is underused in the treatment of bipolar mood disorder. More research with better study design is needed to define the predictors of response to c/mECT and to develop c/mECT treatment protocols for treatment-resistant bipolar patients.

PMID: 12621271

14: J Geriatr Psychiatry Neurol. 2003 Mar;16(1):32-8.

Recorded delirium in a national sample of elderly inpatients: potential implications for recognition.

Kales HC, Kamholz BA, Visnic SG, Blow FC.

This retrospective study examined delirium and related confusional diagnoses recorded in patients older than age 60 discharged from Veterans Affairs (VA) acute inpatient units nationally in 1996 (n = 267,947). Only 4% of patients had delirium or

related confusional diagnoses recorded. Patients with recorded delirium had significantly higher mortality than did those without recorded delirium or those with other confusional diagnoses ("organic psychoses"); the most common delirium types were dementia with delirium and alcohol intoxication/withdrawal delirium. Organic psychoses patients had the longest lengths of stay and significantly more admissions to nonmedical/surgical units and discharges to nursing homes; almost 20% were African American. The recorded rate of delirium in the VA health system likely underestimates true prevalence and possibly reflects nonrecognition of delirium in many older veterans. Certain motoric and etiologic types of delirium may be more commonly diagnosed and recorded. Future research should prospectively examine recognition of motoric and etiologic delirium subtypes and racial differences in delirium diagnoses.

PMID: 12641371

15: JAMA. 2003 Mar 19;289(11):1436-7.

Comment on:

JAMA. 2003 Mar 19;289(11):1396-404.

Treating Gulf War veterans' illnesses--are more focused studies needed?

Hotopf M.

PMID: 12636469

16: JAMA. 2003 Mar 19;289(11):1396-404.

Comment in:

J Fam Pract. 2003 Jun;52(6):441-2.

JAMA. 2003 Mar 19;289(11):1436-7.

Cognitive behavioral therapy and aerobic exercise for Gulf War veterans' illnesses: a randomized controlled trial.

Donta ST, Clauw DJ, Engel CC Jr, Guarino P, Peduzzi P, Williams DA, Skinner JS, Barkhuizen A, Taylor T, Kazis LE, Sogg S, Hunt SC, Dougherty CM, Richardson RD, Kunkel C, Rodriguez W, Alicea E, Chiliade P, Ryan M, Gray GC, Lutwick L, Norwood D, Smith S, Everson M, Blackburn W, Martin W, Griffiss JM, Cooper R, Renner E, Schmitt J, McMurtry C, Thakore M, Mori D, Kerns R, Park M, Pullman-Moore S, Bernstein J, Hershberger P, Salisbury DC, Feussner JR; VA Cooperative Study #470 Study Group.

CONTEXT: Gulf War veterans' illnesses (GWVI), multisymptom illnesses characterized by persistent pain, fatigue, and cognitive symptoms, have been reported by many Gulf War veterans. There are currently no effective therapies available to treat GWVI. OBJECTIVE: To compare the effectiveness of cognitive behavioral therapy (CBT), exercise, and the combination of both for improving physical functioning and reducing the symptoms of GWVI. DESIGN, SETTING, AND PATIENTS: Randomized controlled 2 x 2 factorial trial conducted from April 1999 to September 2001 among 1092 Gulf War veterans who reported at least 2 of 3 symptom types (fatigue, pain, and cognitive) for more than 6 months and at the time of screening. Treatment assignment was unmasked except for a masked assessor of study outcomes at each clinical site (18 Department of Veterans Affairs [VA] and 2 Department of Defense [DOD] medical centers). INTERVENTIONS: Veterans were randomly assigned to receive usual care (n = 271), consisting of any and all care received from inside or outside the VA or DOD health care systems; CBT plus usual care (n = 286); exercise plus usual care (n = 269); or CBT plus exercise plus usual care (n = 266). Exercise sessions were 60 minutes and CBT sessions were 60 to 90 minutes; both met weekly for 12 weeks. MAIN OUTCOME MEASURES: The primary end point was a 7-point or greater increase (improvement) on the Physical Component Summary scale of the Veterans Short Form 36-Item Health Survey at 12

months. Secondary outcomes were standardized measures of pain, fatigue, cognitive symptoms, distress, and mental health functioning. Participants were evaluated at baseline and at 3, 6, and 12 months. RESULTS: The percentage of veterans with improvement in physical function at 1 year was 11.5% for usual care, 11.7% for exercise alone, 18.4% for CBT plus exercise, and 18.5% for CBT alone. The adjusted odds ratios (OR) for improvement in exercise, CBT, and exercise plus CBT vs usual care were 1.07 (95% confidence interval [CI], 0.63-1.82), 1.72 (95% CI, 0.91-3.23), and 1.84 (95% CI, 0.95-3.55), respectively. The OR for the overall (marginal) effect of receiving CBT (n = 552) vs no CBT (n = 535) was 1.71 (95% CI, 1.15-2.53) and for exercise (n = 531) vs no exercise (n = 556) was 1.07 (95% CI, 0.76-1.50). For secondary outcomes, exercise alone or in combination with CBT significantly improved fatigue, distress, cognitive symptoms, and mental health functioning, while CBT alone significantly improved cognitive symptoms and mental health functioning. Neither treatment had a significant impact on pain. CONCLUSION: Our results suggest that CBT and/or exercise can provide modest relief for some of the symptoms of chronic multisymptom illnesses such as GWVI.
PMID: 12636462

17: Mil Med. 2003 Mar;168(3):252-6.

Overweight, obesity, and associated disease burden in the Veterans Affairs ambulatory care population.

Nowicki EM, Billington CJ, Levine AS, Hoover H, Must A, Naumova E.

BACKGROUND: This report describes the prevalence of overweight and obesity and estimates the disease burden associated with excess weight in ambulatory Veterans Affairs (VA) patients. METHODS: Height and weight were measured, and self-reported age and self-reported morbidities were obtained for 1,731 patients.

Prevalence odds ratios explain the association of self-reported disease on increasing weight status category using body mass index. RESULTS: Seventy-five percent of the participants were overweight or obese. Obesity was significantly higher in the younger patients. Graded increases in odds ratios were observed with increasing severity of overweight and obesity for all morbidities, except heart disease.

CONCLUSION: Overweight, obesity, and associated disease burden are prevalent in the VA health care system, particularly in younger VA patients, which may contribute to the higher prevalence of certain morbidities observed in VA populations compared with private sector outpatients. Department of Veterans Affairs should emphasize obesity prevention and treatment during the design and implementation of ambulatory care services.

PMID: 12685694

18: Mil Med. 2003 Mar;168(3):239-45.

Long-term health effects of exposure to sarin and other anticholinesterase chemical warfare agents.

Page WF.

In a telephone survey of 4,022 military volunteers for a 1955-1975 program of experimental exposures to chemical agents at Edgewood, Maryland, the current health of those exposed to anticholinesterase agents was compared with that of men exposed to no active chemicals (no chemical test) and to two or more other types of chemical agents (other chemical tests). The survey posed questions about general health and about neurological and psychological deficits. There were only two statistically significant differences: volunteers in anticholinesterase agent tests reported fewer attention problems than those in other chemical tests and greater sleep disturbance than those in no chemical tests. In contrast, volunteers who reported exposure to civilian or military chemical agents outside of their participation

in the Edgewood program reported many statistically significant adverse neurological and psychological effects, regardless of their experimental exposure. In this study, the health effects of self-reported, nonexperimental exposure, which are subject to recall bias, were greater than the health effects of experimental exposure.
PMID: 12685692

19: Mil Med. 2003 Mar;168(3):186-93.

Identifying new diseases and their causes: the dilemma of illnesses in Gulf War veterans.

Gardner JW, Gibbons RV, Hooper TI, Cunnion SO, Kroenke K, Gackstetter GD. Since the Gulf War, investigation continues of symptoms and illnesses among its veterans. Yet, identifying a specific "Gulf War Syndrome" remains elusive. With new disease entities, causal associations are relatively easily established when the condition is serious, verifiable, and has excess disease rates in specific groups. In common conditions, many excess cases are required to establish association with a specific exposure. Establishing causality in syndromes with variable symptoms is difficult because specific diagnostic algorithms must be established before causal factors can be properly investigated. Searching for an environmental cause is futile in the absence of an operational disease case definition. Common subjective symptoms (without objective physical or laboratory findings) account for over one-half of all medical outpatient visits, yet these symptoms lack an identified physical cause at least one-third of the time. Our medical care system has difficulty dealing with disorders where there is no identified anatomic abnormality or documented metabolic/physiological dysfunction.

PMID: 12685682

20: Pain. 2003 Mar;102(1-2):79-85.

Visceral and cutaneous hypersensitivity in Persian Gulf war veterans with chronic gastrointestinal symptoms.

Dunphy RC, Bridgewater L, Price DD, Robinson ME, Zeilman CJ 3rd, Verne GN. Approximately 697000 United States military personnel participated in the Persian Gulf War (PGW) between August 1990 and March 1991. By April 1997, over 25% of veterans reported chronic health complaints of underdetermined etiology. Gastrointestinal symptoms were among the most frequently reported symptoms including abdominal pain and diarrhea. The objectives of this study were (1). to determine if PGW veterans chronic abdominal pain and diarrhea exhibit visceral and cutaneous hypersensitivity, (2). to determine if these differences in pain sensitivity are significantly associated with psychological stress. A total of 12 veterans (ten males, two females) (39+/-9 years) who were deployed to the Persian Gulf were enrolled. Seven civilians without prior military experience (five males, two females) and five veterans (five males) who had previously been deployed for active combat were enrolled as controls (35+/-9 years). All 12 PGW veterans reported chronic abdominal pain and diarrhea (negative diagnostic workup) that developed during their tour of duty in the Persian Gulf region. All patients completed a battery of psychological assessments and then randomly received experimental visceral (rectal distension of 35 and 55 mmHg for 30s) and cutaneous (immersion of right foot in 45 and 47 degrees C water for 30s) pain stimuli after which they rated their pain intensity and pain unpleasantness on a continuous visual analogue scale (M-VAS) scale. The trials were repeated and the mean M-VAS scores for the two trials were recorded for each subject. In comparison to controls, PGW subjects reported statistically significant higher mean ratings of pain intensity and pain unpleasantness in response to 35 and 55 mmHg rectal distention ($P<0.001$) and in response to 45 and 47 degrees C water immersion ($P<0.001$) of the hand and foot. Results of the

hierarchical regressions indicated that the psychological measures (i.e. anxiety, somatic focus) accounted for a significant amount of variance in each of the pain measures. PGW veterans who developed chronic abdominal pain and diarrhea during their tour of duty exhibit visceral hypersensitivity similar to patients with the irritable bowel syndrome. These veterans also have cutaneous hypersensitivity and higher levels of anxiety and somatic focus accounting for these differences in pain reporting. PMID: 12620599

21: Pharmacotherapy. 2003 Mar;23(3):333-8.

Effect of levofloxacin coadministration on the international normalized ratios during warfarin therapy.

Yamreudeewong W, Lower DL, Kilpatrick DM, Enlow AM, Burrows MM, Greenwood MC.

STUDY OBJECTIVE: To evaluate the effect of levofloxacin coadministration on the international normalized ratio (INR) in patients receiving warfarin therapy. DESIGN: Prospective analysis. SETTING: Outpatient clinic at a Veterans Affairs medical center. PATIENTS: Eighteen adult patients receiving warfarin. INTERVENTION: On the basis of clinical diagnosis and judgment, levofloxacin was prescribed to the 18 patients for treatment of various types of infection. The INR was measured before and at 2-8-day intervals after the coadministration of levofloxacin therapy, and once after completing therapy. Warfarin dosages were adjusted when necessary.

MEASUREMENTS AND MAIN RESULTS: Warfarin dosages were changed in seven patients as a result of the first nontherapeutic INR values obtained after start of levofloxacin therapy. Owing to a concern regarding noncompliance and the adverse effect of bleeding, warfarin dosage was adjusted in one patient even though his first INR value was in the high end of the therapeutic range (2.98, therapeutic range 2-3). One patient withdrew from the study after the first INR measurement after levofloxacin coadministration. Because of a concern about the possible bleeding complication, warfarin dosage was also adjusted in this patient after obtaining his first INR value. Therefore, only the INR values obtained before and the first INR values obtained after levofloxacin administration were compared to evaluate the effect of levofloxacin on INR determination of warfarin therapy. The INR values obtained before levofloxacin administration did not differ significantly from the first INR values obtained after levofloxacin coadministration (mean +/- SD 2.61 +/- 0.44 vs 2.74 +/- 0.83, 95% confidence interval -0.449-0.196, p=0.419). CONCLUSION: The INR values measured before and after concomitant levofloxacin therapy were not significantly different. However, the ability to detect a significant difference may be affected by the small number of patients studied. Further studies with a larger sample are required to better determine the effect of levofloxacin coadministration on INR monitoring during warfarin therapy

PMID: 12627932

22: Prev Med. 2003 Mar;36(3):265-71.

Effectiveness of a nationally implemented smoking cessation guideline on provider and patient practices.

Ward MM, Doebbeling BN, Vaughn TE, Uden-Holman T, Clarke WR, Woolson RF, Letuchy E, Branch LG, Perlin J.

BACKGROUND: The Agency for Health Care Policy and Research (AHCPR) smoking cessation guideline outlines a set of recommendations for physicians to follow in daily practice. However, the effectiveness of this guideline has not been reported. The goal of this project was to evaluate the effect of the AHCPR smoking cessation guideline on provider practices with smokers and on patient smoking rates.

METHODS: Patient survey and chart review data from 138 Veterans Administration

(VA) acute care medical centers with outpatient facilities were examined. Data were available from both sources in 1996, 1997, and 1998. At the midpoint of this period (1997), the VA recommended the AHCPR smoking cessation clinical practice guideline for implementation throughout the VA healthcare system. RESULTS: From 1996 to 1998, both the chart audit and the patient survey showed a significant increase in the percentage of patients in the VA who were counseled about smoking and a significant decrease in the percentage of patients who smoke. CONCLUSIONS: Because the VA tied the guideline implementation to report cards and other performance-enhancing measures, guideline adherence may have been maximized in this setting. These findings suggest that healthcare systems should take an integrated approach to guideline implementation.
PMID: 12634017

23: Psychiatr Serv. 2003 Mar;54(3):383-8.

Use of VA aftercare following military discharge among patients with serious mental disorders.

Mojtabai R, Rosenheck RA, Wyatt RJ, Susser ES.

OBJECTIVE: This study examined the use of Department of Veterans Affairs (VA) aftercare services among patients with serious mental disorders who were discharged from the military after a first admission to a Department of Defense (DoD) hospital. METHODS: Administrative data from the DoD and VA health systems were linked to identify active-duty servicemen and -women who were hospitalized in a military hospital with a diagnosis of major depression, bipolar disorder, or schizophrenia between 1993 and 1996 and who were subsequently discharged from the military. Split population survival analysis was used to examine separately the correlates of contact with VA outpatient mental health services and, among those who had contact, the time to contact after military discharge. RESULTS: Fifty-two percent of 2,861 identified individuals had received outpatient care from VA mental health clinics by the end of September 1998. The rate of contact was lower than in virtually all studies of aftercare following hospital discharge. Women, older persons, and persons with schizophrenia or bipolar disorder were more likely to contact VA outpatient mental health services than men, younger persons, and those with major depression. Among those who made contact, older persons had a longer time to contact. CONCLUSIONS: Many people who leave the military because of serious mental illness do not receive aftercare from the VA. The reasons for such low rates of contact are not clear. Identifying patients who need aftercare but do not receive it and ensuring that they have access to needed services remains an important challenge for the DoD and the VA.
PMID: 12610248

24: Sleep. 2003 Mar 15;26(2):177-82.

A primary care "friendly" cognitive behavioral insomnia therapy.

Edinger JD, Sampson WS.

OBJECTIVES: This study was conducted to test the effectiveness of an abbreviated cognitive-behavioral insomnia therapy (ACBT) with primary DESIGN: A single-blind, randomized group design was used in which study patients were randomized to either a brief, 2-session ACBT or a similarly brief intervention (SHC) that included only generic sleep hygiene recommendations. SETTING: A university-affiliated Department of Veterans Affairs medical center. PARTICIPANTS: Twenty (2 women) veteran patients (M(age) = 51.0 yrs., SD = 13.7 years) who met criteria for chronic primary insomnia. MEASUREMENTS AND RESULTS: Participants completed sleep logs for 2 weeks and questionnaires to measures insomnia symptoms, sleep-related self-efficacy, and dysfunctional beliefs about sleep before treatment, during a 2-week

posttreatment assessment, and again at a 3-month posttreatment follow-up. Statistical analyses showed that ACBT produced significantly larger improvements across a majority of outcome measures than did SHC. Case-by-case analyses showed that only the ACBT produced consistent positive effects across study patients, and a sizeable proportion of these patients receiving this treatment achieved clinically significant improvements by their study endpoints. Approximately 52% of those receiving the ACBT reported at least a 50% reduction in their wake time after sleep onset, and 55.6% of ACBT-treated patients who entered the study with pathologic scores on an Insomnia Symptom Questionnaire (ISQ), achieved normal ISQ scores by their final outcome assessment. CONCLUSIONS: ACBT is effective for reducing subjective sleep disturbance and insomnia symptoms in primary care patients.

PMID: 12683477